First Health Services Corporation
A Coventry Health Care Company

Financial Administration

VaMMIS Procedure Manual

Version 1.0

June 11, 2008

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] provides protection for personal health information. The regulations became effective April 14, 2003. First Health Services developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by First Health Services Corporation. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Document Version	Date	Name	Comments
1.0	02/04/2008	[redacted] Documentation Mgmt. Team	Creation of document

Table of Contents

Preface

The Procedures Manual for the Virginia Medicaid Management Information System (VaMMIS) is a product of First Health Services Corporation. Individual manuals comprise the series of documents developed for the operational areas of the VaMMIS project. Each document includes an introduction, a functional overview of the operations area, workflow diagrams illustrating the processing required to accomplish each task, and descriptions of relevant inputs and outputs. Where appropriate, decision tables, lists, equipment operating instructions, etc. are presented as exhibits, which can be photocopied and posted at unit workstations. Relevant appendices containing information too complex and/or lengthy to be presented within a document section are included at the end of the document.

Use and Maintenance of this Manual

The procedures contained in this manual define day-to-day tasks and activities for the specified operations area(s). These procedures are based on First Health Services' basic MMIS Operating System modified by the specific constraints and requirements of the Virginia MMIS operating environment. They can be used for training as well as a source of reference for resolution of daily problems and issues encountered.

The unit manager is responsible for maintaining the manual such that its contents are current and useful at all times. A hardcopy of the manual is retained in the unit for reference and documentation purposes. The manual is also available on-line for quick reference, and users are encouraged to use the on-line manual. Both management and supervisory staff are responsible for ensuring that all operating personnel adhere to the policies and procedures outlined in this manual.

Manual Revisions

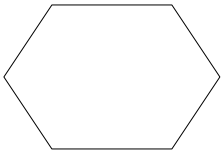
The unit manager and supervisory staff review the manual once each quarter. Review results are recorded on the Manual Review and Update Log maintained in this section of the document. Based on this review, the unit manager and supervisory staff determine what changes, if any, are necessary. The unit manager makes revisions as applicable, and submits them to the Executive Account Manager for review and approval. All changes must be approved by the Executive Account Manager prior to insertion in the manual. When the changes have been approved, the changes are incorporated into the on-line manual. Revised material will be noted as such to the left of the affected section of the documentation, and the effective date of the change will appear directly below. A hardcopy of the revised pages are inserted into the unit manual, and copies of the revised pages are forwarded to all personnel listed on the Manual Distribution List maintained in this section of the manual.

Flowchart Standards

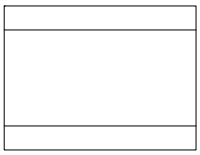
The workflow diagrams included in this document were generated through the flowcharting software product Visio Professional. Descriptions of the basic flowcharting symbols used in the VaMMIS documentation are presented below.

Large Processing Function

Manual Process. No automated processes are used; e.g., clerical function.

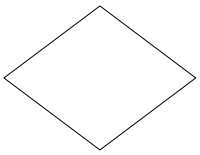


Data Preparation Processing; e.g., mailroom, computer operations, etc.

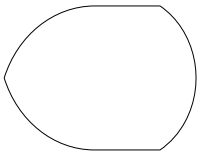


Create a Request

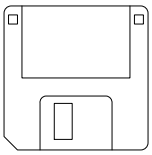
Data maintained in a master datastore.



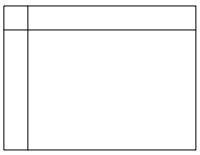
Decision



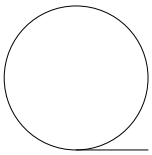
Information entered or displayed on-line.



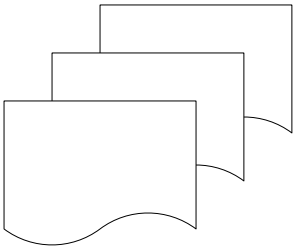
Data stored on diskette media.



On-line Storage; e.g., CD-ROM, microform, imaged data, etc.

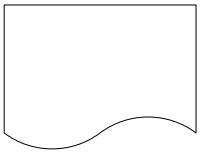


Input or Output Tape



Multiple Outputs; e.g., letters, reports

Communication Link



Single Output; e.g., letter, report, form, etc.

External Entity. Source of entry or exit from a process.

Off-page Connector

1.0 Overview of the Virginia Medical Assistance Program

The Commonwealth of Virginia State Plan under Title XIX of the Social Security Act sets forth the Commonwealth's plan for managing the Virginia Medical Assistance Program (VMAP). It defines and describes the provisions for: administration of Medical Assistance services; covered groups and agencies responsible for eligibility determination; conditions of and requirements for eligibility; the amount, duration, and scope of services; the standards established and methods used for utilization control, the methods and standards for establishing payments, procedures for eligibility appeals; and waivered services.

1.1 Standard Abbreviations for Subsystem Components

For brevity, subsystem components will use these abbreviations as part of their nomenclature.

Abbreviation	Subsystem
AM	Automated Mailing
AS	Assessment (Financial Subsystem)
CP	Claims Processing
DA	Drug Application
EP	EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
FN	Financial Subsystem
MC	Managed Care (Financial Subsystem)
MR	MARs (Management and Reporting)
POS	Point of Sale (Drug Application)
PS	Provider
RF	Reference
RS	Recipient
SU	SURS (Surveillance Utilization and Review)
TP	TPL (Financial Subsystem)

1.2 Covered Services

The Virginia Medical Assistance Program covers all services required by Federal legislation and provides certain optional benefits, as well. Services are offered to Medicaid Categorically Needy and Medically Needy clients. In addition, certain services are provided to eligibles of the State and Local Hospitalization (SLH) program and the Indigent Health Care (IHC) Trust Fund. SLH, Temporary Detention Orders (TDO), and IHC are State and locally funded programs with no Federal matching funds. SLH is a program for persons who are poor, but not eligible for Medicaid in Virginia, which is funded by the Commonwealth and local counties.

Services and supplies that are reimbursable under Medicaid include, but are not limited to:

- Inpatient acute hospital
- Outpatient hospital
- Inpatient mental health
- Nursing facility
- Skilled nursing facility (SNF) for patients under 21 years of age
- Intermediate care facilities for the mentally retarded (ICF-MR)
- Hospice
- Physician
- Pharmacy
- Laboratory and X-ray
- Clinic
- Community mental health
- Dental
- Podiatry
- Nurse practitioner
- Nurse midwife
- Optometry
- Home health
- Durable medical equipment (DME)
- Medical supplies
- Medical transportation
- Ambulatory surgical center.

Many of the services provided by DMAS require a co-payment to be paid by the recipient. This payment differs by type of service being billed, according to the State Plan. Payment made to providers is the net of this amount.

General exclusions from the Medicaid Program benefits include all services, which are experimental in nature, cosmetic procedures, acupuncture, autopsy examination, and missed appointments. In addition, there are benefit limitations for specific service categories that must be enforced during payment request processing.

1.3 Waivers and Special Programs

In addition to the standard Medicaid benefit package, the Commonwealth has several Federal waivers in effect which provide additional services not ordinarily covered by Medicaid, as well as special programs for pregnant women and poor children. The programs include:

- **Elderly and Disabled** is a Home and Community Based Care (HCBC) waiver program covering individuals who meet the nursing facility level-of-care criteria and who are at risk for institutionalization. In order to forestall institutional placement, coverage is provided for:
  - ❒ Personal Care (implemented 1982)
  - ❒ Adult Day Health Care (implemented 1989)
  - ❒ Respite Care (implemented 1989)
- **Technology Assisted Waiver for Ventilator Dependent Children** is a HCBC waiver implemented in 1988 to provide in-home care for persons under 21, who are dependent upon technological support and need substantial ongoing nursing care, and would otherwise require hospitalization. The program has since been expanded to provide services to individuals over age 21.
- **Mental Retardation Waiver** includes two HCBC waivers that were implemented in 1991 for the provision of home and community based care to mentally retarded clients. They include an OBRA waiver for persons coming from a nursing facility who would otherwise be placed in an ICF/MR, and a community waiver for persons coming from an ICF/MR or community. The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) updates the eligibility file for Mental Retardation Waivers.
- **AIDS/HIV Waiver** is a HCBC waiver implemented in 1991 that provides for home and community based care to individuals with AIDS, or who are HIV positive, and at risk for institutionalization.
- **Assisted Living Services** include two levels of payment, regular and intensive. Regular assisted living payments (per day per eligible recipient) are made from state funds. Intensive assisted living payments (per day per eligible recipient) are covered under an HCBC waiver and are made from a combination of state and federal funds.
- **Adult Care Resident Annual Reassessment and Targeted Case Management** provides for re-authorization and/or follow-up for individuals residing in assisted living facilities. The program includes a short assessment process for individuals who are assessed at the residential level, and a full assessment for individuals who are assessed at the regular or intensive assisted living level. The targeted case management is provided to individuals who need assistance with the coordination of services at a level which exceeds that provided by the facility staff.

- **PACE/Pre-PACE Programs** provide coordination and continuity of preventive health services and other medical care, including acute care, long term care and emergency care under a capitated rate.
- **Consumer-Directed Personal Attendant Services** is a HCBC waiver that serves individuals who are in need of a cost-effective alternative to nursing facility placement and who have the cognitive ability to manage their own care and caregiver.
- **MEDALLION Managed Care Waiver** is a primary care physician case management program. Each recipient is assigned a primary care physician who is responsible for managing all patient care, provides primary care, and makes referrals. The primary care physician receives fees for the services provided plus a monthly case management fee per patient.
- **MEDALLION II Managed Care Waiver** is a fully capitated, mandatory managed care program operating in various regions of the State. Recipients choose among participating HMOs, which provide all medical care, with a few exceptions.
- ***Options*** is an alternative to MEDALLION where services are provided through network providers, and the participating HMOs receive a monthly rate based on estimated Medicaid expenditures.
- **Client Medical Management (CMM)** is the recipient "lock-in" program for recipients who have been identified as over utilizing services or otherwise abusing the Program. These recipients may be restricted to specific physicians and pharmacies. A provider who is not the designated physician or pharmacy can be reimbursed for services only in case of an emergency, written referral from the designated physician, or other services not included with CMM restrictions. The need for continued monitoring is reviewed every eighteen (18) months. The services not applicable to CMM are renal dialysis, routine vision care, Baby Care, waivers, mental health services, and prosthetics.
- **Baby Care Program** provides case management, prenatal group patient education, nutrition counseling services, and homemaker services for pregnant women, and care coordination for high risk pregnant women and infants up to age two.

1.4 Eligibility

Medicaid services are to be provided by eligible providers to eligible recipients. Eligible recipients are those who have applied for and have been determined to meet the income and other requirements for the Department of Medical Assistance Services (DMAS) services under Medicaid. Virginia also allows certain Social Security Income (SSI) recipients to "spend down" their income to Medicaid eligibility levels by making periodic payments to providers.

Virginia is a Section 209(b) state, meaning that the DMAS administers Medicaid eligibility for SSI eligibles and State supplement recipients locally through the Department of Social Services (DSS). DSS administers eligibility determination at its local offices and is responsible for determining Medicaid eligibility of Temporary Assistance to Needy Families with Children (TANF), Low-Income Families with Children (LIFC), and the aged. DSS also determines financial eligibility of blind and disabled applicants. In addition, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) administers recipient eligibility for Mental Retardation Waivers. The Department of Visually Handicapped (DVH) and the Department of Rehabilitative Services (DRS) are responsible for determining the degree of blindness of an applicant and the determination of medical necessity, respectively.

Three categories of individuals are eligible for services under the VMAP: Mandatory Categorically Needy, Optionally Categorically Needy, and Optionally Medically Needy. In addition, DMAS operates two other indigent healthcare financing programs, the State and Local Hospitalization (SLH) and the Indigent Health Care (IHC) Trust Fund.

1.5 Eligible Providers and Reimbursement

Qualified providers enroll with the VMAP by executing a participation agreement with the DMAS prior to billing for any services provided to Medicaid eligibles. Providers must adhere to the conditions of participation outlined in the individual provider agreement. To be reimbursed for services, providers must be approved by the Commonwealth and be carried on the Provider Master File in the MMIS.

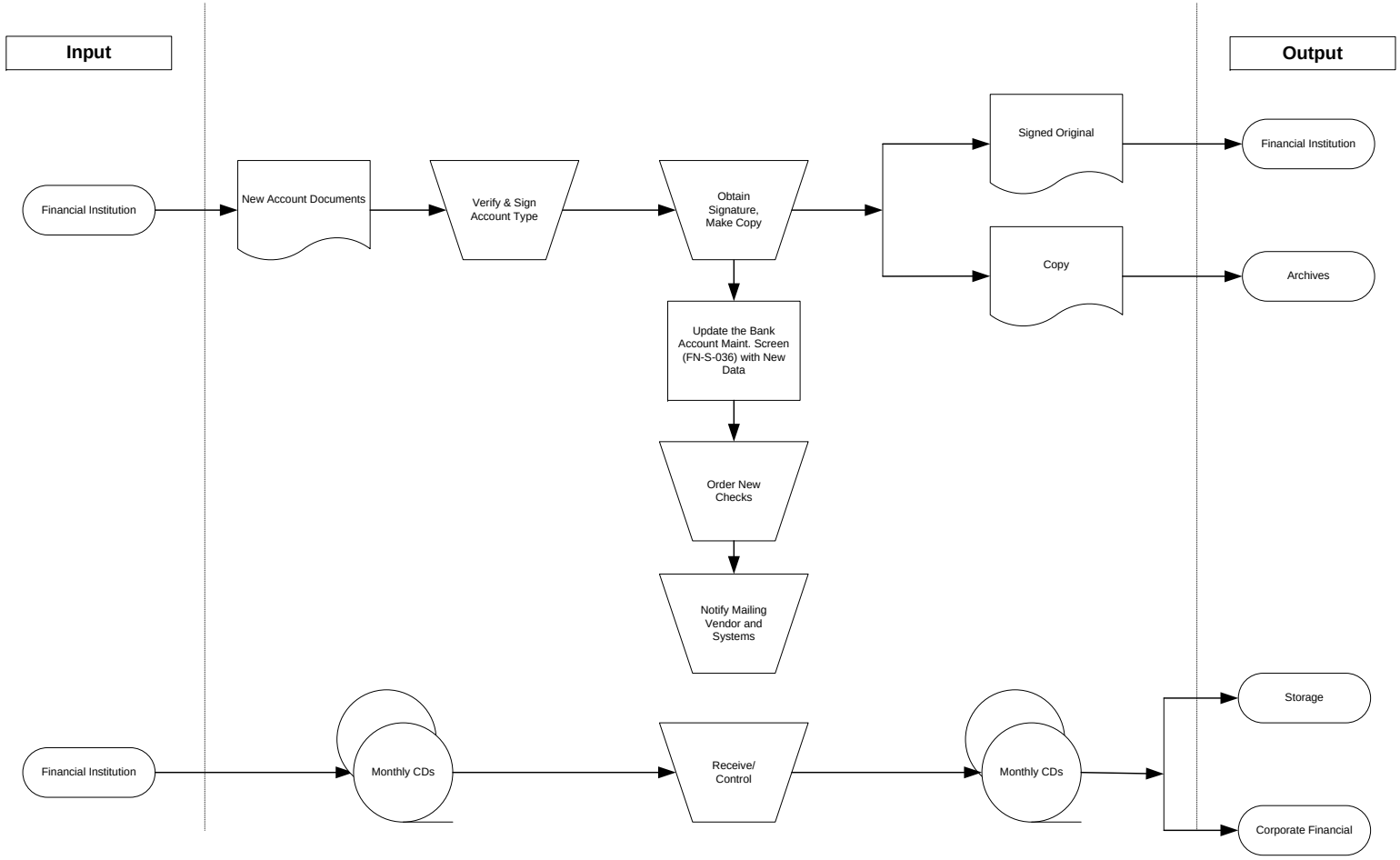
DMAS employs a variety of reimbursement methodologies for payment of provider services. Inpatient hospital and long-term care facilities are reimbursed on a per diem prospective rate, which goes into effect up to 180 days after the beginning of the rate period to allow for retroactive payment adjustments. Settlement is based on a blend of the per diem rate and the APG/DRG Grouper reimbursement methodology. Other providers are reimbursed on a fee-for-service (FFS) basis according to a Geographic Fee File maximum amount allowed. In the FFS methodology, payment is the allowed amount, or the charge, whichever is less; payment is adjusted by co-payment, as well as by any third-party payment. Medicare co-insurance and deductibles received in the crossover system are reduced to the Medicaid allowance when the Medicare payment and the Medicaid co-insurance amount would exceed the Medicaid-allowed amount. In addition to these payment methodologies, the MEDALLION managed care program uses case management fees as well as FSS. MEDALLION II is fully capitated and uses a per member, per month, payment methodology. Health maintenance organizations (HMOs) participating in the Options program are paid a monthly rate based on estimated Medicaid expenditures. Monthly fees are also paid for Client Medical Management (CMM).

2.0 Administer Bank Accounts

First Health Services is responsible for maintaining two bank accounts for claims payment. One account is for Medicaid payments, the other is for FAMIS (Family Access to Medical Security). First Health Services sets up a new account for each program for each new fiscal year, orders check stock, receives and controls the bank account CDs and the Corporate Finance Department reconciles the accounts monthly.

WORKFLOW PROCESS

Financial Procedures: Administer Bank Accounts



2.1 Set Up New Bank Accounts

The fiscal year for the Commonwealth of Virginia ends on June 30. Funds from DMAS are distributed through two accounts each fiscal year, one for Medicaid and one for FAMIS. The Finance Manager contacts the corporate treasury to open new bank accounts each fiscal year. The new account is established prior to the start of the next fiscal year to ensure enough time for the Systems Group to make necessary modifications.

Procedures

1. Starting April 1st, contact corporate treasury (currently [redacted] CLPIOT@cvty.com and request to open two new zero balance accounts (ZBA).
2. When you receive the blank forms:
   - ❖ Enter *First Health Services Corporation* as the name.
   - ❖ Enter the TIN as [redacted].
   - ❖ Give the completed form to the Senior Director of Virginia Operations for signature;
     - – Submit the signed form to all other individuals authorized to sign.
3. When the new forms have been signed and returned:
   - ❖ Make one copy and distribute to the Administrative Assistant of VAMMIS for maintenance on file.
   - ❖ Mail the original signed documents to the corporate treasurer.

Updating the Bank Account Maintenance Screen (FN-S-036)

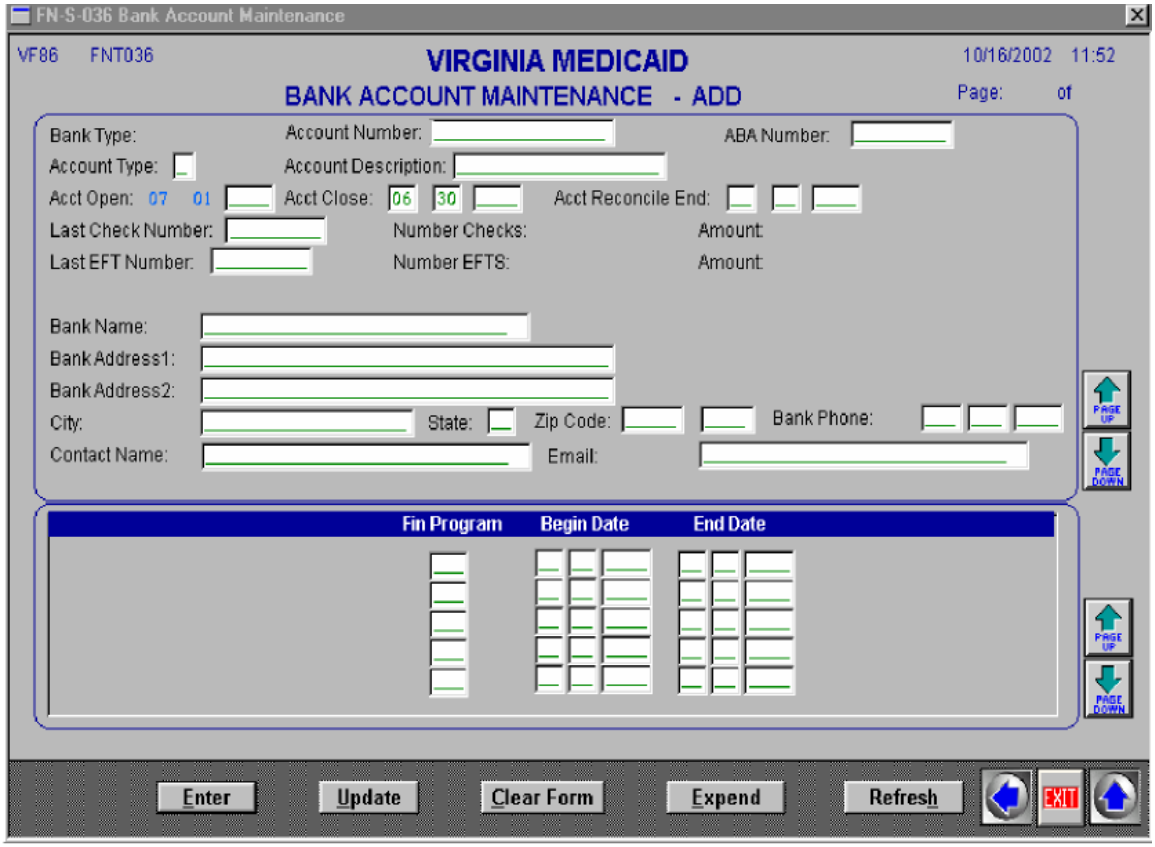
The Finance Control Manager or Analyst must add all of the new account information on the Virginia Medicaid Bank Account Maintenance – Add screen (FN-S-036) before the new fiscal year begins for the program. The screen should be updated prior to the processing of the first weekly cycle dated after June 30th of any year.

There will be two new bank accounts that will need to be updated: One for the Medicaid and the second for FAMIS accounts.

Refer to the VAMMIS On-line Documentation under Financial/Screens to update the highlighted fields displayed on FN-S-036 (Financial Bank Account Maintenance) screen. Instructions for each field are documented under the UM Field Instructions column Maintenance section. Example of screen FN-O-036 on the following page.

- Enter the last check number for Medicaid and FAMIS as 000004999, leave the last EFT number blank. This is an arbitrary number and ensures no overlap in check numbers, etc.

- The FIN programs for Medicaid are 321, 456, 461, 464, 466, 479 and 499.
- The FIN program for FAMIS is 446.



2.2 Order New Checks

New checks must be ordered for each new bank account opened. The mailing vendor orders the checks for the automated checks and Finance orders the stock for manual checks.

Procedures

1. Select a different color for each separate account, i.e., FAMIS or Virginia Medicaid.
2. When written confirmation that the accounts are open is received from the financial institution, contact the check vendors to notify them of relevant information.
3. Notify the Systems Manager, via e-mail, of the new bank account numbers and beginning check numbers.
4. Notify DMAS of the new account numbers.
5. When the manual checks are received from the vendor, store them in the Corporate vault located onsite.

Note: (RA) Automated Check Vendor: [redacted]

6. Notify the RA vendor of the following details:
   - ❖ Color selected for each account.
   - ❖ Beginning check number for each account.
   - ❖ New checking account number for each account.

   Note: Manual Check Vendor: [redacted]

7. Contact [redacted] to order the manual check stock, and notify them of the following details:
   - ❖ Color selected for each account.
   - ❖ Beginning check number for each account.
   - ❖ New checking account number for each account.
   - ❖ Quantity of checks to print.

2.3 Receive/Control Bank Account CDs

Financial institutions send account activity for each bank account on CD each month by [redacted]. This data is used by Corporate Finance to reconcile the bank accounts to the program financial records. The CDs are then forwarded to Finance where control and routing to the appropriate user is performed.

Procedures

1. Each month, receive a copy of current bank account CDs (cashed checks) from the bank.
2. Place each account CD in file cabinet within Finance.

2.4 Evaluate the Provider Application for EDI/EFT/POS Registration

To finish processing the application, see if the provider wants to enroll in the EDI/EFT/POS electronic data interchange programs. If the proper documents are attached to the provider application, you can process the provider's request. All EFT requests are processed by the Financial Analyst. All EDI requests are processed by the EDI Coordinator.

Procedures

1. Read the questions listed below and answer them based on information in the provider enrollee package.
2. Follow the instructions in this response grid.

If the Provider is applying as a point of Sale provider, is an electronic POS application included and does it meet all these criteria? If yes, enter the POS required information.

Is an EDI/ERA registration form included in the enrollment package?

Answer	Do This
Yes	Forward the EDI registration application to the EDI Coordinator.

Is an EFT registration form included in the enrollment package?

Answer	Do This
Yes	Forward the EFT registration application to the Financial Analyst.

2.5 Enroll a Provider in EFT

First Health Services', Financial Unit offers Medicaid providers the opportunity to have their Medicaid and FAMIS (formerly CMSIP) checks automatically deposited in the account of their choice through our EFT program. EFT is an acronym for Electronic Funds Transfer, which is defined as the technology that allows for funds to be transferred securely by electronic means from one bank account to another. Note: Inquiries from providers regarding specific fund transfers or account information should always be forwarded to the EFT Representative.

Requesting Enrollment

A provider requests EFT enrollment through the First Health Services, VAMMIS, Provider Enrollment Unit. Requests may be received via telephone, fax, or written correspondence. When an EFT request is received, the Provider Enrollment Representative responds to the request by either mailing or faxing the EFT Request Letter and Application to the provider. These forms can be accessed from the following locations on our local network:

N:\groups\vpeu\Procedures\EFT\EFT request letter

N:\groups\vpeu\Procedures\EFT\Electronic Funds Transfer Application

Providers may also download the EFT application from the Provider Enrollment section of the Virginia Department of Medical Assistance Services (DMAS) web site at the following Internet web address: http://www.dmas.virginia.gov

Additionally, the EFT Request Letter and Application should be included with enrollment packages being sent to new providers who are requesting enrollment into VA Medicaid for the first time.

EFT Enrollment Requirements

In order for a provider to participate in First Health Services' EFT program, the provider must initiate the enrollment process by submitting an Electronic Funds Transfer Application to the VAMMIS Provider Enrollment Unit (PEU). For an application to be valid it must meet the following criteria:

- It must have an original signature
- Only one bank account may be designated
- A voided check, deposit slip, or official letter from the financial institution must be attached.

If the application does not meet the requirements, a letter is generated to the provider that stipulates why the application is being rejected. The application is returned to the provider with the rejection letter. A copy of the rejection letter is recorded in Hummingbird.

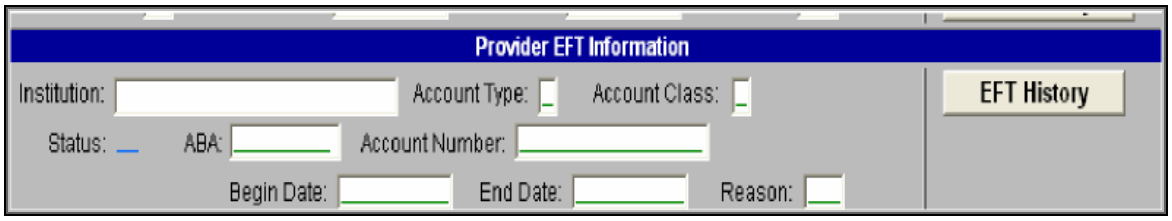
If the EFT application meets the specified requirements, the EFT Representative completes the enrollment process using the following procedures:

Procedures

From the VAMMIS Main System Menu:

1. Open the **VAMMIS Main Menu** and navigate to the **Provider Information/Enrollment** screen.
2. Choose the **Provider** button.
3. You see the **Provider Main Menu** screen (PS-S-000).
4. Choose *Provider Information* from the drop-menu in the **Selection** field.
5. Choose the **Add** or **Change** radio button in the **Function** field.
6. Enter the NPI in the **ID Value** field.
7. Choose **Enter**.
8. You see the **Provider Information** screen (PS-S-001).
9. Add EFT information in the **EFT History** panel.

Note: For detailed descriptions and directions for the fields in this panel, see the on-line HELP system.



10. An acknowledgement of EFT enrollment is generated during the nightly processing for each provider in which an EFT file record is added. These confirmation letters are mailed by PEU on the next business day.

EFT Provider Inquiries

1. If no listing for an EFT Application is returned, the Provider Enrollment Representative should advise the provider that the application has not been received as of yet and suggest that the provider inquire again in a few business days.
2. If a listing for an EFT Application is returned, the Provider Enrollment Representative should advise the provider that the application has been received and proceed to confirm whether or not processing has been completed.
    - ❖ If the application has been received and deemed unacceptable for processing, a rejection letter should be recorded in Hummingbird. The Provider Enrollment Representative should access the rejection letter and advise the provider of the documented reject reason and the steps necessary to successfully resubmit the application.
    - ❖ If the application has been received and does not have a rejection letter recorded in Hummingbird, the Provider Enrollment Representative should query the VAMMIS to confirm that the EFT application has been entered.

2.6 Common EFT Questions and Answers

Q: If a provider has multiple provider numbers, do they have to complete an individual EFT application for each provider number.

A: No. They can complete one application and enclose a separate document listing all provider numbers that need to be enrolled in the EFT program.

Note: Only one bank account may be designated

Q: If a provider does not have checks for their account, what other documentation can be submitted with the EFT application to verify their account information?

A: A provider may also submit a deposit slip from their account or an official letter from the financial institution stating the account's ABA routing and account numbers.

Q: Will providers still receive their corresponding remittances as normal once enrolled in the EFT program?

A: Remittances are still received normally and will include a duplicate check verifying the funds deposited into the provider's account.

Q: If a corporate entity has multiple physicians that they would like to enroll in the EFT program, do the individual physicians have to sign the EFT Application?

A: No. A representative of the organization (i.e. Administrator, Financial Officer, etc.) may sign the application(s).

2.7 Definition of Terms

EFT: EFT is an acronym for Electronic Funds Transfer, which is defined as the technology that allows for funds to be transferred securely by electronic means from one bank account to another.

ABA Routing Number: ABA is an acronym for American Bankers Association. An ABA Routing Number is a 9-digit number assigned to a financial institution by the American Bankers Association to identify the bank which is responsible to either pay or give credit or is entitled to receive payment or credit for a financial transaction and provide the capability for transactions to be transmitted and delivered for settlement in an efficient and timely manner.

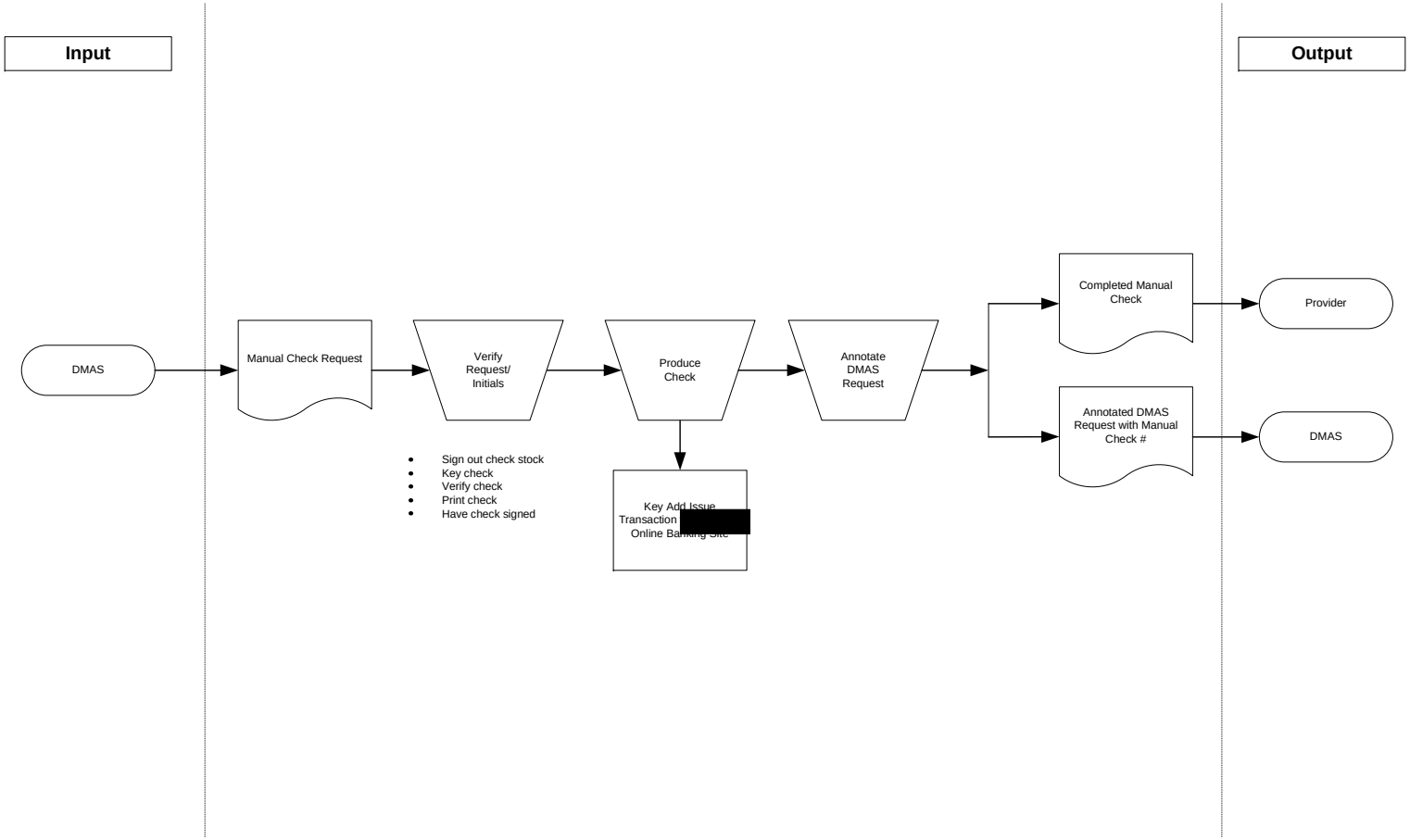
3.0 Issue Manual Checks

Periodically, DMAS will request issuance of a manual check to advance provider monies prior to the weekly checkwrite. DMAS submits recoveries to be processed in the next cycle to begin collecting the monies from the providers. These advance payments are then automatically recouped by the MMIS as claims are adjudicated through the cycle. Manual checks are also requested to replace lost or stolen checks, which are issued only with the proper DMAS authorization. Before the replacement of a previous check is issued, a stop payment must be issued through the bank to ensure the check has not been cashed and will not be cashed in the future.

DMAS may also request a manual check to replace an automated check previously issued. The automated check is voided and reissued, when an original check has been lost, never received, stolen, misplaced or stale dated. Before the replacement manual check is issued, a stop payment must be issued through the bank to ensure that the check has not been cashed and will not be cashed in the future.

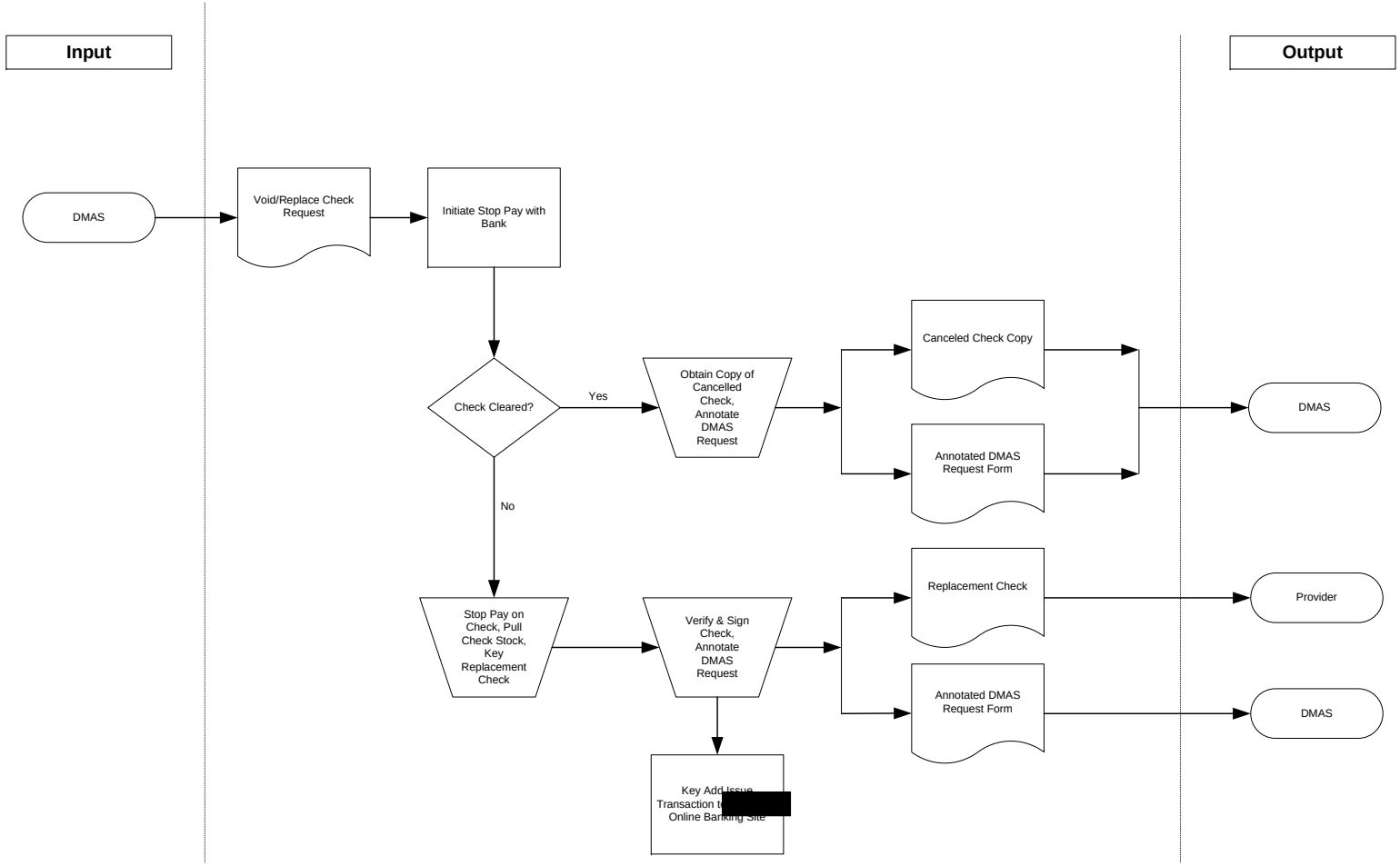
WORKFLOW PROCESS

Financial Procedures: Issue Manual Checks



WORKFLOW PROCESS

Financial Procedures: Void/Replace Checks



3.1 Receive/Verify DMAS Request for Manual Check

DMAS submits a completed Advance Check Request form to request issuance and delivery of a manual check to a provider or vendor before the next scheduled adjudication cycle. The request is usually emailed to Finance. The FN-I-005 (Recoupment, Add Pay and Recovery Financial Transaction Form) must be included in order for First Health Services to enter the data into the MMIS. A similar form (Replacement Check Request) is used by DMAS to request a replacement check (void/reissue) for a lost or stolen check previously issued by the system. The replacement form is also used by the EFT Coordinator in the event of EFT rejections.

The form includes instructions for the check to be issued and the method of distribution. See Appendix A, Forms, for examples.

All check requests received from DMAS are forwarded to Finance, who immediately begins processing the request.

These DMAS staff (Fiscal Division) are authorized to approve advances:

- TBD •
- Suzie Church

These DMAS staff (Program Operation Division) are authorized to request checks:

- Tom Edicola
- John Tabb
- Karen Moss
- Toni Bell

These FH staff are authorized to request checks:

[redacted]

Procedures

1. Review the Check Request for completeness, accuracy, and legibility.
2. If the check request is for an advance check, go to Section 4.4 – Process EFT Rejections. Otherwise, continue.

3.2 Stop Payment (Check Cancel)

If a previously issued automated check is to be replaced, a stop payment must first be issued for the original check. This is accomplished through the [redacted] capability. Stop payments can be initiated only by Finance staff who have security clearance with the bank.

Procedures

1. Access the [redacted] from your web browser. Link https://wc.wachovia.com/. Refer to Appendix C for sign on procedures.
2. Select the **Account Reconciliation** icon from the menu. Refer to Appendix C.
   - ❖ If the check has not been cashed, the pay date is blank. Request a stop payment (check cancel) be placed on that check. See Appendix C**.**
     - – Enter *Y* on the **Check Request** form in **Stop?** column.
     - – Note the date stopped in the **Comments** section.
   - ❖ If the check has been cashed, access the [redacted] and retrieve and print front and back copies of the check. See Appendix C**.**
     - – Note on the **Check Request** form in the **Comments** section: *Cashed on (date).*

3.3 Photocopy a Request

A photocopy of the Check Cancel transaction may also be requested from the Account Reconciliation screen of the Online Business Banking System.

Procedures

1. Access the [redacted] from your web browser: Link [redacted]. Refer to Appendix C for sign on procedures.
2. Select the **Account Reconciliation** icon from the menu. Refer to Appendix C.
3. Print a copy for the file.

3.4 Produce Manual Check

Once the check request has been verified, the check stock is removed from the secure location and the manual check is keyed, printed, verified and signed.

Procedures

1. Go to the check vault and sign out checks to be written in the Check Register Log (See Appendix B, Logs)**.** Two different signatures are required to sign out checks.
2. Load the check stock face up in the printer.
3. Select *N:\groups\vmap\qc\Check Stock* and the appropriate document. These are form field documents. See Appendix A, Forms, for examples.

   ✍ *Do not press the Enter key when keying a form.*

4. The selected screen displays and the current date is automatically generated and displayed. Type the provider number and press the **Tab** key.
5. Type the void after date. It must be 6 months from the current date.
6. Type the provider name and press the **Tab** key.
7. Type the dollar amount of the check and press the **Tab** key.
8. Type the cent amount of the check and press the **Tab** key.
9. Type the Attention line data and press the **Tab** key,

   OR

   Just press the **Tab** key to skip the Attention line.
10. Type line 1 of the address and press the **Tab** key.
11. Type line 2 of the address and press the **Tab** key. Option: Just press **Tab** to skip line 2.
12. Type the city, state and zip code.
13. Press the **Print** icon to print the check.
14. After check(s) are printed, verify the appropriate data, print quality, and alignment.
15. Refer to the appropriate individual for signature.

3.5 Add Issue

Once a manual check is written an add issue must be entered. This is accomplished through the [redacted] capability. Add issues can be initiated only by Finance staff who have security clearance with the bank.

Procedures

1. Access the [redacted] from your web browser: Link [redacted]. Refer to Appendix C for sign on procedures.
2. Select Account Reconciliation from the menu. Refer to Appendix C.
    - ❖ Click on the drop down to select the account name for which the check was written.
    - ❖ Once the account name is selected the account number will appear in the next field.
    - ❖ Type the serial (check) number and press the **Tab** key.
    - ❖ Click on the drop down and choose the current month and press the **Tab** key.
    - ❖ Click on the drop down and choose the current day and press the **Tab** key.
    - ❖ Click on the drop down and choose the current year and press the **Tab** key.
    - ❖ Enter in the dollar amount, keying the decimal place and press the **Tab** key.
    - ❖ Enter the NPI and press the **Enter** key. If it is the legacy number, enter an *L* in front of the number.
    - ❖ Click on *ADD*.
3. Refer to Appendix C for detailed instructions on submitting the add issues once all checks are entered.

3.6 Update Financial Master Inquiry/Update Screen (FN-S-007)

Once the check is keyed, printed, verified and signed the transaction is entered in the MMIS. Finance must enter the information from the FN-I005 (9500 series transacations) or the FN-I-008 (6100 series transactions) form to screen (FN-S-007) before the new check is disbursed.

Procedures

1. Enter the data from the form.
2. Refer to the VAMMIS On-line Documentation under Financial/Screens on FN-S-007 (Financial Master Inquiry/Update) screen for explicit instructions for each field.
3. Write the FCN on the finance form submitted by the requestor.
4. Write the new check number on the finance form submitted by the requestor.
5. Take the form to the appropriate person to be approved.

6. The approver will go to FN-S-043 and verify the information was entered correctly and approve.
7. If any data is incorrect, it is denied and reprocessed.

3.7 Route Check and DMAS Request

Once the check is keyed, printed, verified and signed, the check is disbursed and documentation is routed to DMAS.

DMAS can request special handling for disbursement of provider checks; some of the special carriers are listed below:

- [redacted] – must use DMAS or provider's account number for billing.
- [redacted] – must use DMAS or provider's account number for billing.
- [redacted] (mail).
- Provider pick-up.

Procedures

1. Write the new check number on the Check Request form submitted by DMAS.
2. Have the Finance Analyst sign the check form.
3. Prepare each signed manual check for routing by courier, mail or signed pick-up according to the instructions on the Check Request form. Deliver the item(s) to the Mailroom. Methods of distribution can include:
    - ❖ [redacted] (must be prepared and delivered to the Mailroom by 4 p.m. each day)
    - ❖ [redacted] (must be prepared and delivered to the Mailroom by 3 p.m. each day)
    - ❖ [redacted] (mail) (must be prepared and delivered to the Mailroom by 4 p.m. each day)
    - ❖ Provider pick-up (may be picked up in the Main Lobby anytime before 4 p.m.). Only providers authorized by DMAS can pick up checks. At the time of pick-up, the receptionist in the Lobby notifies Finance. Finance staff delivers the check to the Lobby:
        - – Obtain the provider's picture ID (i.e., driver's license).
        - – Make a copy of the ID.
        - – Have the individual sign and date the copy of the picture ID.
        - – Release the check to the provider.
        - – File the signed and dated copy of the ID in the Finance Unit.

4. At the end of the workday, fax each annotated, signed, Check Request form back to the DMAS originator.

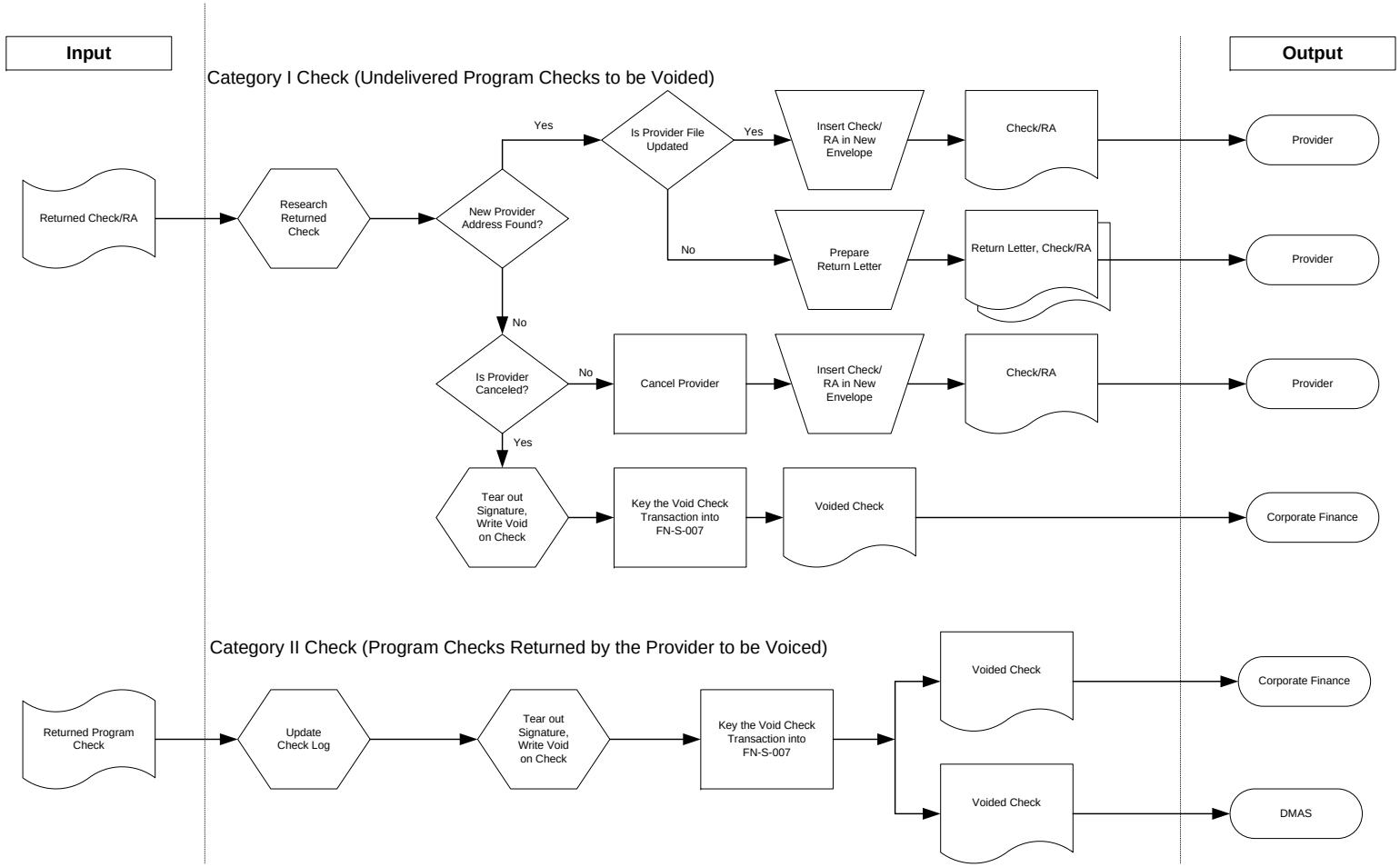
4.0 Process Provider/Vendor Checks

The Finance Unit receives, controls and processes five categories of payments:

- Category I - Undelivered program checks to be voided.
- Category II - Program checks returned by the provider to be voided.
- Category III - Personal checks submitted by providers to refund overpayments.
- Category IV - EFT rejected by the financial institution.
- Category V - HIPP checks returned by DMAS to be voided.

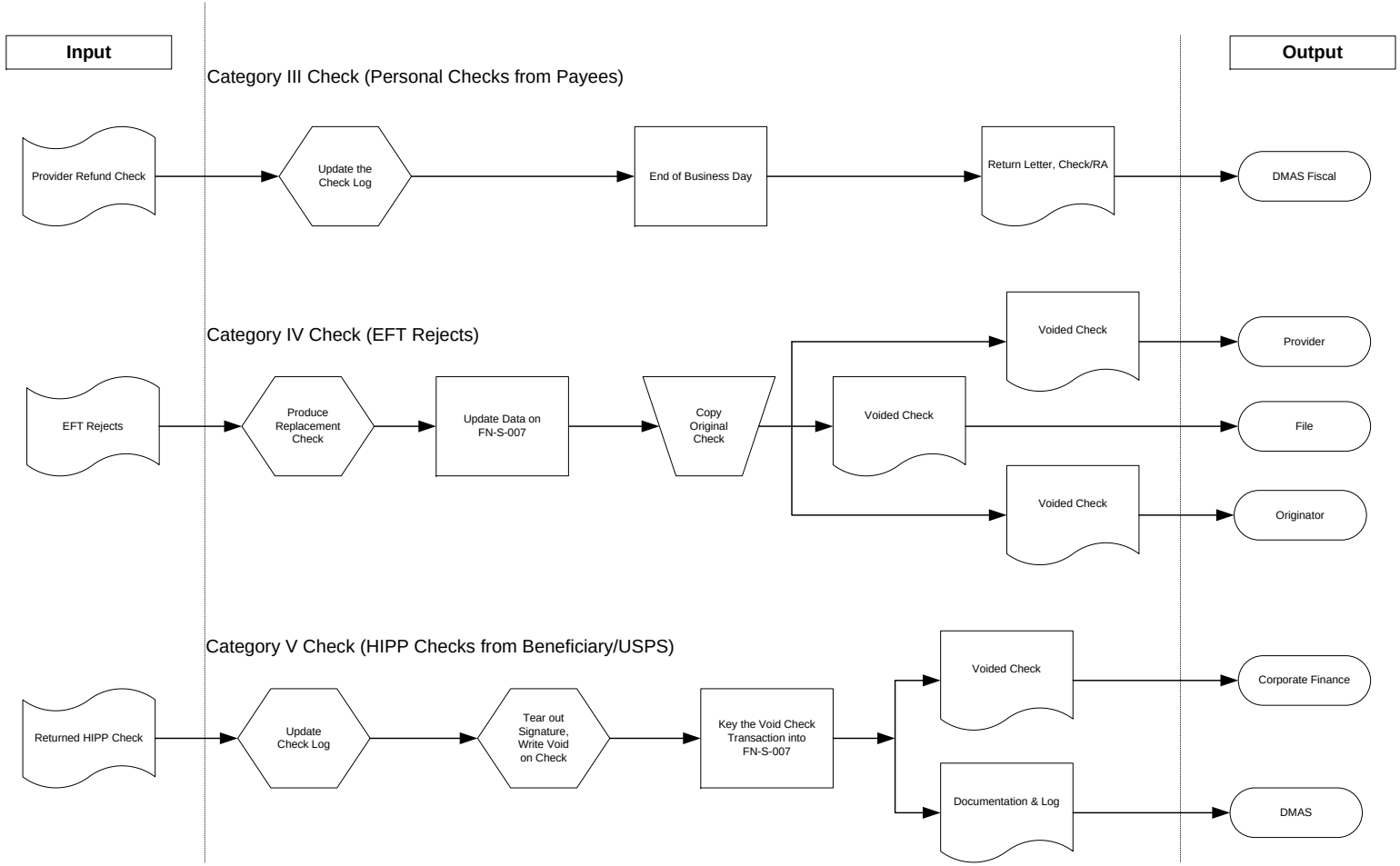
WORKFLOW PROCESS

Financial Procedures: Process Provider Checks



WORKFLOW PROCESS

Financial Procedures: Process Provider Checks



4.1 Process Undelivered Checks (Category 1)

Finance receives undelivered checks on a daily basis. If a valid address for the provider is found, the check is re-mailed.

Procedures

1. On each returned check, look up the address in the provider file.
2. If the provider number is not valid, it is a vendor check.
   - ❖ Go to CICS, click on *Financial*.
   - ❖ Select *Financial Master Maintenance Menu*, *Check Inquiry* and press **Enter**.
   - ❖ Select *Financial Payee Inquiry/Update Screen*, Check Inquiry, select *Payee ID*, type the vendor number as the payee ID and press **Enter**.
   - ❖ If there is a 7-digit number in the Payee Xref ID, it is probably a HIPP check. Refer to Section 4.5 - Process Returned HIPP Checks.
3. For envelopes with a [redacted] Yellow label or a new address indicated.
   - ❖ If the address is different than the address on the label: - Update the provider file with the new address.
     - – Write the provider number on the yellow label, attach the label to a piece of paper and route to PEU to be imaged.
     - – Mail the check to the new address.
   - ❖ If the address is the **same** as the address on the label: - Mail the check to the new address.
4. If the address has not been changed, route the HIPP returned check to DMAS-Pam Gilbert for research.
   - ❖ On the envelope to the left of the address, indicate with the initial below where the envelope was mailed:
     - – S = servicing
     - – M = mail
     - – P = payment remittance
   - ❖ On the envelope above **FIRST CLASS MAIL,** indicate the provider number.
   - ❖ If there is another address, write it on the envelope above the words **RETURN SERVICE REQUESTED** with the appropriate initial to the left.
   - ❖ Check [redacted] for a new address.

- Call the provider's contact number given in VAMMIS and ask for the new information to be faxed or in writing via [redacted]. Write the contact # on the envelope to the right of **DEPARTMENT OF MEDICAL ASSISTANCE SERVICES.** Indicate with whom you spoke. Add 3 days to the current day and place the envelope in that cancel folder. For instance, you called on Tuesday, place the envelope in Friday's cancel folder.

5. If there is no answer, number is disconnected, message or fax is not returned within 48 hours and envelope was mailed to either the servicing address or the payment address:
   - **EXCEPTION –** If PCT is 01, 10, 15, or 87 OR program code 02 is active, route to the PEU supervisor for further processing.
   - If another address is on file:
     - Complete letter **Return Mail Cancel Letter** (see example) and mail envelope to the other address.
     - Save the letter in [redacted] or make a copy and send to PEU as "image only."
     - Cancel the provider number with an end date 2 months in the future (add 2 months to the current date) with the cancel reason code of *007***.**
     - Near the contact # on the envelope, write a *C***.**
   - If another address is not on file:
     - Go to [redacted] and try finding a phone number for the provider. If no number is found, mail letter **Return Mail Request Letter** (see example) to the address on file for "good faith" efforts.
     - Save the letter in [redacted] or make a copy and send to PEU as "image only."
6. Periodically throughout the day check for incoming faxes.
   - Update the file.
   - Route the fax to PEU as image only.
7. If the file is already canceled, the returned check must be voided.
8. Write *VOID* on the original check.
9. Key the Void Check transaction on the MMIS Financial Master Maintenance screen (FN-S-007). Refer to the Financial User Manual for access and keying instructions, and field definitions.
10. Category I Provider Undelivered checks are entered as *6001***.**
11. Cut out the signature.

12. Route the voided check to Corporate Finance to be shredded.

4.2 Process Checks Returned by Providers (Category II)

Periodically, providers return program checks and request the check be voided, or report that the check does not belong to the provider.

Procedures

1. Daily any provider/vendor checks received in the mail are logged by Data Prep on a Category II logsheet. See Appendix B, Logs, for an example.
2. The checks/documentation and logsheet are then routed to Finance.
3. If the checks arrive in another manner such as, an inner-office envelope, add to the day's category logsheet.
4. If the provider/vendor number is not on the logsheet, Finance will enter it.
5. Void the physical check. To do this:
   - ❖ Write *VOID* on the check.
   - ❖ Cut out the signature.
6. Key the Void Check transaction on the MMIS Financial Master Maintenance screen (FN-S-007). Refer to the Financial User Manual for keying instructions and field definitions.
   - ❖ Category II Provider checks are entered as *6003***.**
7. Route the voided check to Corporate Finance to be shredded.
8. Copy the logsheet.
9. Place the documentation in an inner-office envelope along with the copy of the logsheet and address to DMAS – Karen Moss.
10. File the original logsheet in Finance.

4.3 Process Provider Refund Checks (Category III)

Providers submit refund (personal/business) checks to return overpayments. These checks are delivered to Finance from Data Prep daily. After they are logged in, they are routed to DMAS for deposit, research and posting to the MMIS Financial Subsystem.

Procedures

1. Daily any provider checks received in the mail are logged by Data Prep on a Category III logsheet. See Appendix B, Logs, for an example.
2. The checks/documentation and logsheet are then routed to Finance.
3. If the checks arrive in another manner such as, an inner-office envelope, add to the day's Category III logsheet.
4. If the provider name is not on the logsheet, Finance will enter it.
5. Copy the logsheet.
6. Place the documentation/checks in an inner-office envelope along with a copy of the logsheet and address to DMAS Accounting.
7. File the original logsheet in Finance.

4.4 Process EFT Rejections (Category IV)

Periodically, rejections are received from the bank for electronic fund transfers which did not complete due to a variety of reasons.

Procedures

1. Any EFT rejections are received in PEU, researched and resolved. If it is necessary to issue a manual check to replace the rejected EFT, a Replacement Check request is completed. See Appendix B, Logs, for an example.
2. The replacement check request is then routed to Finance.
3. Refer to Section 3.4 - Produce Manual Check for instructions of how to process the check request.
4. Key the Void Check transaction on the MMIS Financial Master Maintenance screen (FN-S-007). Refer to the Financial User Manual for keying instructions and field definitions.
    - ❖ Category IV EFT checks are entered as *6101*.
5. Copy the request.
6. Route the documentation along with the copy of the request to PEU – Edwin Davis.
7. File the original request in Finance.

4.5 Process Returned HIPP Checks (Category V)

Periodically, recipients return HIPP program checks and request the check be voided.

Procedures

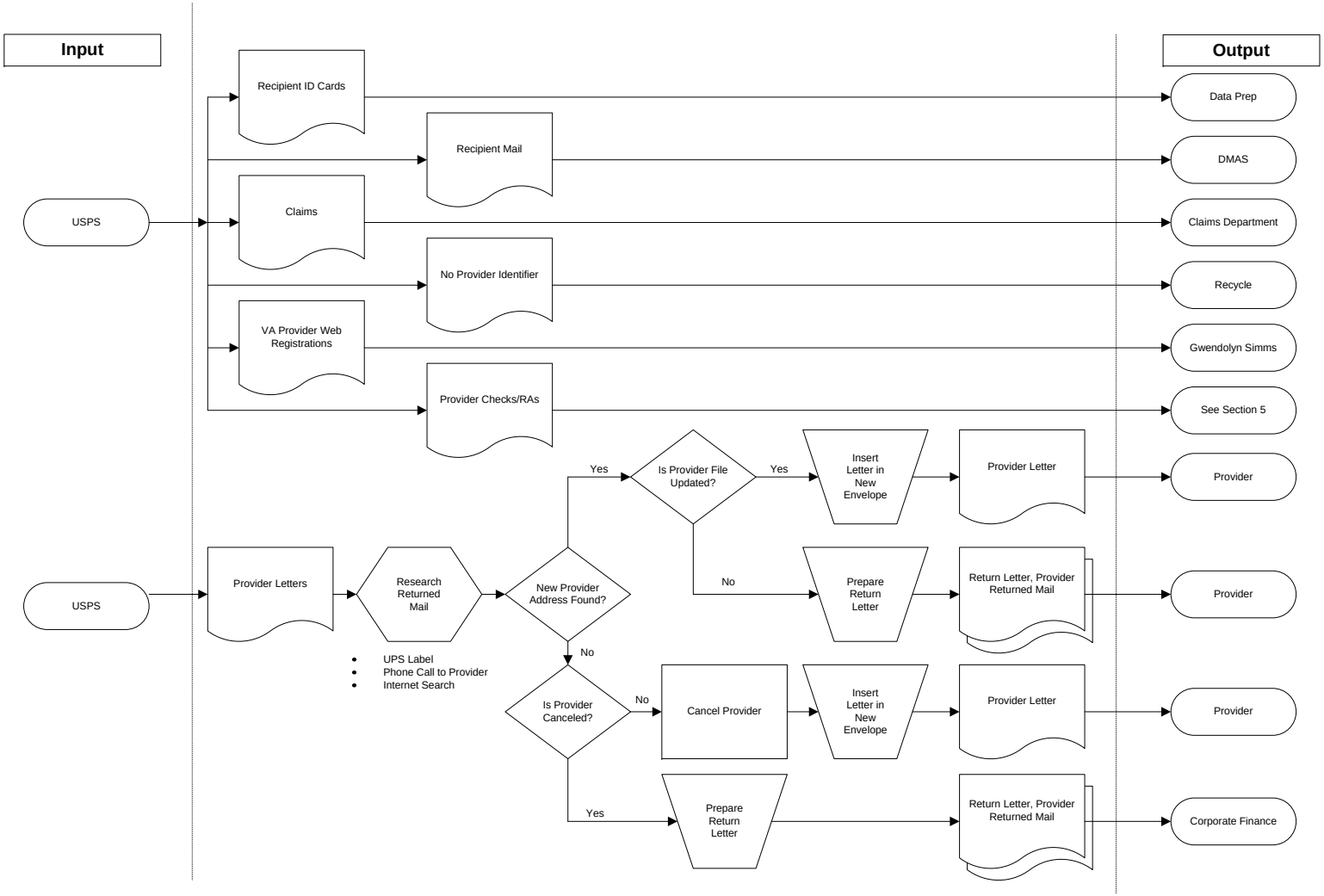
1. HIPP checks are logged by DMAS on a Category V logsheet. See Appendix B, Logs, for an example.
2. The checks and logsheet are then routed to FH Finance.
3. If the checks arrive in another manner such as regular mail, (they can be identified by the 10 digit vendor number on the check), add to the day's category V logsheet.
4. Void the physical check. To do this:
    - ❖ Write *VOID* on the check.
    - ❖ Cut out the signature.
5. Key the Void Check transaction on the MMIS Financial Master Maintenance screen (FN-S-007). Refer to the Financial User Manual for keying instructions and field definitions.
    - ❖ Category V HIPP checks are entered as *6005***.**
6. Route the voided check to Corporate Finance to be shredded.
7. Copy the logsheet.
8. Place the documentation in an inner-office envelope along with the copy of the logsheet and address to DMAS – Pam Gilbert.
9. File the original logsheet in Finance.

5.0 Process Returned Mail

The Finance Unit receives, controls, and processes returned provider mail.

WORKFLOW PROCESS

Financial Procedures: Process Returned Mail



5.1 Process Returned Mail

Finance receives returned mail from PEU on a daily basis. It must be sorted and resolved according to procedures listed below.

Procedures

1. Sort the mail by the following types:
    - ❖ Recipient ID cards.
    - ❖ Recipient mail.
    - ❖ Claims.
    - ❖ No provider identifier.
    - ❖ Provider checks and remits.
    - ❖ VA Providers Web Registration
    - ❖ Letters with the Medicaid ID embedded within the first address line.
2. Route the recipient ID cards to Data Prep.
3. Route recipient mail to Customer Service at DMAS.
4. Route the claims to the originating department.
5. Route the Web Registration mail to Gwendolyn Simms inter-office at

   9881 Mayland DR 2nd FL.
6. Recycle the “no provider identifier” mail.
7. For the provider checks and remits, refer to Section 4.1 - Process Undelivered Checks (Category I) for detailed guidelines.
8. On each returned envelope, look up the address in the provider file.
9. For envelopes with a [redacted] Yellow label or a new address indicated:
    - ❖ If the address is different than the address on the label:
        - – Update the provider file with the new address (each occurrence). **EXCEPTION: Do NOT update the servicing address.**
            - ◆ If servicing is the only address given, go to step 10c.
        - – Write the provider number on the yellow label, attach the label to a piece of paper and route to PEU as “image only.”
        - – Mail to the new address.
    - ❖ If the address is the same as the address on the label:

- Mail to the new address.

10. For envelopes with no new address information on file:
    - ❖ On the envelope to the left of the address, indicate with the initial below where the envelope was mailed:
      - S = servicing
      - M = mail
      - P = payment
      - R = remittance
    - ❖ On the envelope above **FIRST CLASS MAIL,** indicate the provider number.
    - ❖ If there is another address, write it on the envelope above the words **RETURN SERVICE REQUESTED** with the appropriate initial to the left.
    - ❖ Check [redacted] for a new address.
      - Call the provider's contact number given in VAMMIS and ask for the new information to be faxed or in writing via [redacted]. Write the contact # on the envelope to the right of **DEPARTMENT OF MEDICAL ASSISTANCE SERVICES.** Indicate with whom you spoke. Add 3 days to the current day and place the envelope in that cancel folder. For instance, you called on Tuesday, place the envelope in Friday's cancel folder.
11. If there is no answer, number is disconnected, message or fax is not returned within 48 hours **and** envelope was mailed to either the **servicing** address or the **payment** address:

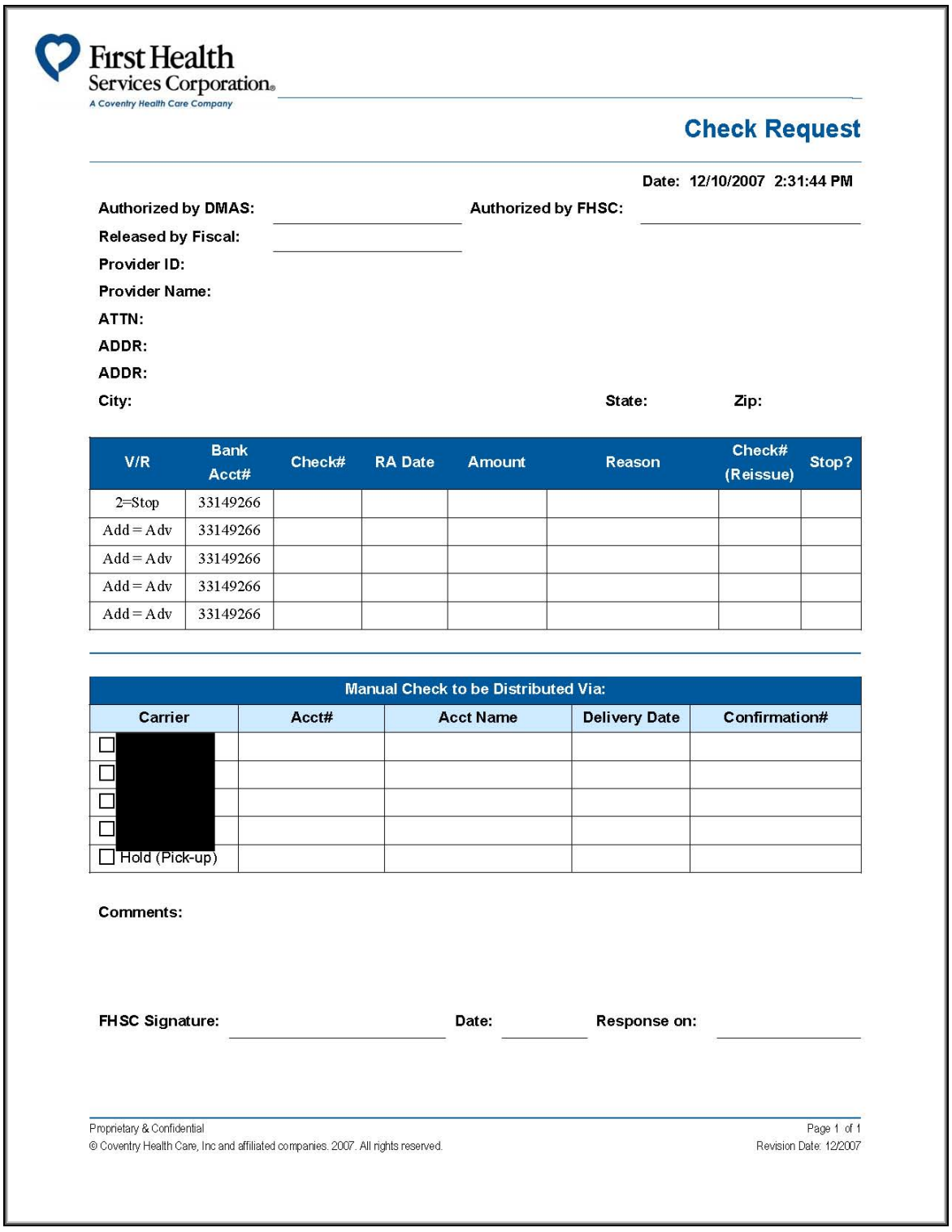
    EXCEPTION – If PCT is 01, 10, 15, or 87 OR program code 02 is active, route to the PEU supervisor for further processing.

    - ❖ If another address is on file:
      - Complete letter **Return Mail Cancel Letter** (see example) and mail envelope to the other address.
      - Save the letter in [redacted] or make a copy and send to PEU as "image only."
      - Cancel the provider number with an end date 2 months in the future (add 2 months to the current date) with the cancel reason code of *007***.**
      - Near the contact # on the envelope, write a *C***.**
    - ❖ If another address is not on file:
      - Go to [redacted] and try finding a phone number for the provider. If no number is found, mail letter **Return Mail Request Letter** (see example) to the address on file for "good faith" efforts.

- Save the letter in [redacted] or make a copy and send to PEU as “image only”.

12. If there is no answer, number is disconnected or message is not returned within 48 hours and envelope was mailed to either the correspondence address or the remittance address:
    - ❖ If another address is on file:
        - Complete letter **Return Mail Request Letter** and mail envelope to the other address.
        - Remove invalid address from the provider’s file.
        - Save the letter in [redacted] or make a copy and send to PEU as “image only”.
        - Near the contact # on the envelope, write an ***R*.**
    - ❖ If another address is not on file: this should not occur. See your supervisor
13. Periodically throughout the day check for incoming faxes.
    - ❖ Update the file.
    - ❖ Route the fax to PEU as image only.

Appendix A Forms



First Health Services Corporation
A Coventry Health Care Company

Check Request

Date: 12/10/2007 2:31:44 PM

Authorized by DMAS: _____ Authorized by FHSC: _____

Released by Fiscal: _____

Provider ID:

Provider Name:

ATTN:

ADDR:

ADDR:

City: State: Zip:

V/R	Bank Acct#	Check#	RA Date	Amount	Reason	Check# (Reissue)	Stop?
2=Stop	33149266						
Add = Adv	33149266						
Add = Adv	33149266						
Add = Adv	33149266						
Add = Adv	33149266						

Manual Check to be Distributed Via:				
Carrier	Acct#	Acct Name	Delivery Date	Confirmation#
☐ [redacted]				
☐				
☐				
☐				
☐ Hold (Pick-up)				

Comments:

FHSC Signature: _____ Date: _____ Response on: _____

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Page 1 of 1
Revision Date: 12/2007

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
RECOUPMENT, ADD PAY AND RECOVERY
FINANCIAL TRANSACTION FORM FN-I-005

REASON CODES
(1)

RECOUPMENT INCREASE: _____ **CASH RECEIPT (Recovery):** _____
(1000 - 1999) **(8000 - 8999)**

RECOUPMENT DECREASE: _____ **PAYMENTS (Addpay):** _____
(2000 - 2999) **(9000 - 9999)**

PAYEE NAME: _____ **PAYEE ID:** _____
(2) (3)

PAYEE TYPE: _____
(4)

BENEFIT PROGRAM CODE: _____ **TRANSACTION AMOUNT $** _____
(5) (6)

(REASON CODES 8000 - 8999)

CHECK NUMBER: _____ **RECEIPT NUMBER:** _____
(7) (8)

CHECK DATE: _____
(9 MM/DD/CCYY)

(REASON CODES 1200 - 1299)

BEGIN DATE: _____ **END DATE:** _____
(10 MM/DD/CCYY) (11 MM/DD/CCYY)

RECOUPMENT LIMIT: _____ **RECOUPMENT LIMIT$** _____
(12 PERCENTAGE) (13 AMOUNT)

FISCAL YEAR: _____
(14 MMYY)

FUND/FUND DETAIL: _____ / **FUND SPLIT:** _____ % **OBJECT CODE:** _____
_____ / _____ % (17 Ex. 123401)
_____ / _____ %
_____ / _____ % **LOCAL CODE:** _____
(15 Ex. 01/000) (16 Ex. 50) (18)

COMMENTS: _____
_____
_____
(19)

PREPARED BY: _____ **DATE:** _____
(20) (21 MM/DD/CCYY)

AUTHORIZED SIGNATURE: _____ **DATE:** _____
(22) (23 MM/DD/CCYY)

FCN: _____ **PUBLIC / PRIVATE:** _____
(24) (25)

Revised 11/16/2007, 1:46 PM 6/2003

Appendix B Logs

TOTAL: _____ **CATEGORY II (First Health Checks) CHECK LOG** DATE: _____

	CHECK #	RA/CHECK DATE	PROVIDER #	CHECK AMT	DP	FIN	DMAS
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

C:\Documents and Settings\BishopTe\Desktop\05860\Financial Administration\CAT II log.doc

Page _____ of _____

TOTAL: _____ **CATEGORY III (Personal Checks) CHECK LOG** DATE: _____

	CHECK #	RA DATE	PROVIDER NAME	CHECK AMT	DP	FIN	DMAS
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

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Page _____ of _____

TOTAL: _____ **CATEGORY V (First Health Checks) CHECK LOG** DATE: _____

	CHECK #	RA/CHECK DATE	VENDOR #	CHECK AMT	DP	FIN	DMAS
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							

C:\Documents and Settings\BishopTe\Desktop\05860\Financial Administration\CAT V log.doc

Page _____ of _____

Appendix C [redacted]